



**STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGULATION AND LICENSURE –DIVISION OF INVESTIGATIONS
P.O. Box 95164, Lincoln, Nebraska 68509-5164
402-471-0175**

HEALTH CARE PROFESSIONAL SELF-REPORTING ADVERSE ACTION

INDICATE THE TYPE OF SITUATION YOU ARE REPORTING:

- ☐ Loss or Voluntary Limitation of Privileges ☐ Resignation from Staff ☐ Loss of Employment
☐ Professional Liability ☐ Credential Denied or Disciplined ☐ Membership Lost ☐ Court Conviction

IDENTIFYING INFORMATION – COMPLETE ALL ITEMS

Name:	First:	Middle/MI	Last:	Maiden:
Work Address:	Street/PO/Route:			
	City:	State:	Zip:	
Home Address:	Street/PO/Route:			
	City:	State:	Zip:	
Telephone	Home:		Work:	
Optional	Cell Phone		E-Mail Address	

LIST THE FIELD AND NUMBER FOR EACH NEBRASKA LICENSE, CERTIFICATE OR REGISTRATION HELD

License Field	License Number

PATIENT OR CLIENT NAME ASSOCIATED WITH THIS REPORT

Name:	Address	
City	State	Zip
Date of Birth		

FACILITY, BOARD, ASSOCIATION, JURISDICTION, EMPLOYER, OR HOSPITAL ASSOCIATED WITH THIS REPORT

Name:	Address	
City	State	Zip

LOSS OR VOLUNTARY LIMITATION OF PRIVILEGES OR RESIGNATION FROM STAFF OR LOSS OF EMPLOYMENT REPORT
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1. ☐ I lost my privileges in a hospital or other health care facility due to alleged:
 - ☐ Incompetence
 - ☐ Negligence
 - ☐ Unethical or unprofessional conduct
 - ☐ Physical, mental or chemical impairment

2. ☐ I voluntary limit my privileges or resigned from the staff of a health care facility while under the formal or informal investigation or evaluation by the facility or a committee of the facility for issues of:
 - ☐ Clinical incompetence
 - ☐ Unprofessional conduct
 - ☐ Physical, mental or chemical impairment

3. ☐ I lost my employment due to alleged:
 - ☐ Incompetence
 - ☐ Negligence
 - ☐ Unethical or unprofessional conduct
 - ☐ Physical, mental or chemical impairment

Date the above action occurred:	
Date of Incident that lead to 1, 2 or 3 above:	
Name of person investigating or acting on privileges or employment:	
Name of Facility:	
Address:	
Telephone Number:	
Facility Incident occurred at if different:	Name:
	Address:

Describe the conduct, omission or other reason that caused your loss of employment or affected your privileges.
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PROFESSIONAL LIABILITY REPORT

1. ☐ I had a professional liability claim that resulted in an adverse judgement, settlement or award, including settlements made prior to suit. OR
2. ☐ My professional liability insurance coverage has been cancelled, limited or otherwise modified due to a professional liability claim. OR
3. ☐ I have been refused professional liability insurance coverage on an initial or renewal basis due to professional liability claim.

Date(s) on which the act(s) or omission(s) which gave rise to the action or claim occurred:			
Date the action or claim was filed with a court or other adjudicative body:			
Date of <input type="checkbox"/> judgement <input type="checkbox"/> settlement or <input type="checkbox"/> award:		Day	Month
Date of Payment		Year	
Amount			
Case Number			
Name of court or adjudicative body	Name		
	Address		
	City	State	Zip
Insurer, employer, other person or entity making payment of the claim	Name		
	Address		
	City	State	Zip
	Contact Person:		Telephone No.
Patient, client or other person to whom or for whose behalf payment was made	Name		Telephone No.
	Address		
	City	State	Zip
Location where act(s) or omission(s) occurred	Name		
	Address		
	City	State	Zip
Description of the act(s) or omission(s) upon which the action was based.			

Use additional paper if necessary.

CREDENTIAL DENIED OR DISCIPLINED, MEMBERSHIP LOST OR COURT CONVICTION REPORT

1. ☐ I was denied a credential or other form of authorization to practice by a state, territory, or other jurisdiction, including any military or federal jurisdiction, due to alleged:
- ☐ Incompetence
 - ☐ Negligence
 - ☐ Unethical or unprofessional conduct
 - ☐ Physical, mental or chemical impairment
2. ☐ I had disciplinary action taken against a credential or other form of permit by another state, territory, or jurisdiction, including any federal or military jurisdiction, or I had a settlement of such action, or I voluntarily surrendered or had a limitation placed on my credential or other form of permit.
3. ☐ I lost my membership in a professional organization due to alleged:
- ☐ Incompetence
 - ☐ Negligence
 - ☐ Unethical or unprofessional conduct
 - ☐ Physical, mental or chemical impairment

Board, Association, Organization or Jurisdiction Taking Action	Name		Telephone No.
	Address		
	City	State	Zip
	Date Action Taken	Date Action Effective	Duration of Action
Nature of the action and description of any terms and conditions:			

4. ☐ I was convicted of a misdemeanor or felony in Nebraska or another state, territory or jurisdiction, including any federal or military jurisdiction. (Do not report speeding or parking tickets.)

Name of Court	City	State	Zip
Date of Conviction	Case Number	Under appeal ? <input type="checkbox"/>	
		To: _____ Court	
Name of crime for which convicted			
Sentence imposed, including duration and any terms and conditions:			